



## Missouri Pharmacy Program – Preferred Drug List



### Homozygous Familial Hypercholesterolemia

*Effective 01/29/2014*

*Revised 01/08/2015*

#### Preferred Agents

#### Non-Preferred Agents

- Kynamro®
- Juxtapid®

### Approval Criteria

- Diagnosis of Homozygous Familial Hypercholesterolemia (ICD-9 272.0) (ICD-10 E78.0)
- Trial and failure of High-Potency Statin therapy
  - Atorvastatin 80mg/day **or**
  - Rosuvastatin 40mg/day
- ADE/ADR to High-Potency Statin therapy
- LDL-C remains > 175

### Denial Criteria

- Claims for patients under 18 years of age.
- Pregnancy
- Moderate or severe hepatic impairment (based on Child-Pugh category B or C) or with active liver disease, including unexplained persistent elevations of serum transaminases.
- Dosage exceeds FDA limitations
  - Juxtapid 60 mg/day
  - Kynamro 200 mg/wk
- Approval criteria not met
- Drug Prior Authorization Hotline: (800) 392-8030